



Assignment of Insurance Benefits Form

Assignment of Benefits:

I request that payment of authorized insurance or Medicaid benefits be made either to me or on my behalf to Sandpiper Pediatrics, PLLC for any services furnished me by the provider/clinic. I authorize any holder of medical information about me or my dependent to release to the insurance company or to CMS (Centers for Medicare and Medicaid Services) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. In Medicaid assigned cases, the physician or supplier agrees to accept the charge determination of the Medicaid carrier as full charge and the patient is only responsible for non-covered services.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY SAID INSURANCE.

Patient Name: _____ Date of Birth: _____

Parent/Guardian: _____ Relation to patient: _____

Parent/Guardian Signature: _____

Date: _____